



# Reporting Form for Animal Bites

also available at: <http://www.bphc.org/bphc/animalbite.pdf>

**Fax Completed Form to BPHC-CDC 24 hours a day at (617) 534-5905.**

If assistance is needed with animal follow-up, call Boston Animal Control at (617) 635-5349.

### I. Exposed Person Information (please print)

Last Name		First Name		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	D.O.B. ___/___/___	
Address			Apt. #	City		State	Zip
Phone	Other Phone	If a minor, Name of Parent or Guardian			Parent/Guardian Phone		

### II. Exposure Information

Date of Exposure ___/___/___	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Location (address)		
Animal: <input type="checkbox"/> Wild <input type="checkbox"/> Domestic	<input type="checkbox"/> Dog <input type="checkbox"/> Cat	<input type="checkbox"/> Bat <input type="checkbox"/> Raccoon	<input type="checkbox"/> Ferret <input type="checkbox"/> Skunk <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	Description (Breed, Color, Sex)
Any pertinent animal testing/vaccination:			Animal Specimen Sent for Rabies Test <input type="checkbox"/> Yes, Date ___/___/___ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Type of Exposure: <input type="checkbox"/> Bite <input type="checkbox"/> Scratch <input type="checkbox"/> Saliva to mucous membrane <input type="checkbox"/> Other <b>direct contact</b> with animal (describe): _____	<input type="checkbox"/> Indirect contact with pet/ animal following that animal's exposure to another suspect rabid animal <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____	Circumstances surrounding incident: (please describe) _____ _____ _____		

### III. Medical Information

Seen by Medical Provider? <input type="checkbox"/> Yes, Date of Visit ___/___/___ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Medical record #	Name of Provider
Facility	Phone	
Name of Primary Care Provider (PCP)	PCP Facility	Phone
Description of wound (location on body, severity, number, etc.)		

### IV. Treatment Information

HRIG (Human Rabies Immune Globulin) <input type="checkbox"/> Yes, Date: ___/___/___ <input type="checkbox"/> No	Tetanus (Td) <input type="checkbox"/> Yes, Date: ___/___/___ <input type="checkbox"/> No
HDCV (Human Diploid Cell Rabies Vaccine) <input type="checkbox"/> Yes, Date: ___/___/___ <input type="checkbox"/> No	Previous Post-Exposure or Pre-Exposure Prophylaxis for Rabies <input type="checkbox"/> Yes, Date: ___/___/___ <input type="checkbox"/> No
If HDCV series has been initiated, please note facility where subsequent injections will be given. Facility: _____	Other Treatment/Medication:

### V. Animal Owner/Facility Information

Last Name	First Name	Owner known by victim? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Address	Apt. #	City	State	Zip
Current Location of Animal (if different from above)				

### VI. Person Completing Form

Name	Phone	Worksite	Date
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**FAX COMPLETED FORM TO 617-534-5905**